



Assignment of Benefits & Release of Medical Information to Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the audiologist(s) or supplier listed below for any services provided to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other insurance coverage is listed on my claim form or electronic claim, my signature authorizes release of information to the insurer shown. In Medicare-assigned cases, the audiologist or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. This assignment is valid from today's date and remains in effect until I, the patient, revoked this assignment.

Patient signature

Date

Patient name (please print)

____-____-____-____
Medicare Number & Letter